BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2011-673
ERIN KELLY FOREST AKA ERIN KELLY ORTMANN **P.O. Box 392** **Camarillo, CA 93011**	**DEFAULT DECISION AND ORDER**
Registered Nurse License No. RN 683607	[Gov. Code, §11520]
Respondent.	

FINDINGS OF FACT

1. On or about February 1, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-673 against Erin Kelly Forest (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about July 17, 2006, the Board of Registered Nursing (Board) issued Registered Nurse License No. RN 683607 to Respondent. The Registered Nurse License expired on May 31, 2010, and has not been renewed.

3. On or about February 1, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2011-673, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of

Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board, which was and is:

P.O. Box 392
Camarillo, CA 93011.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

6. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-673.

7. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

8. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2011-673, finds that the charges and allegations in Accusation No. 2011-673, are separately and severally, found to be true and correct by clear and convincing evidence.

9. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for investigation and enforcement is $18,991.25 as of March 1, 2011.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Erin Kelly Forest has subjected her Registered Nurse License No. RN 683607 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Business & Professions Code sections 490 and 2761, subdivisions (a), (d) and (f), in conjunction with California Code of Regulations, Title 16, section 1444, for unprofessional conduct, in that Respondent was convicted on October 6, 2010 of violating Penal Code section 459 [burglary- felony], and of violating Penal Code section 368, subdivision (e) [elder abuse-misdemeanor], in *People v. Erin K. Forest*, Superior Court of California, County of Ventura Case No. 2010018201, crimes which are substantially related to the qualifications, functions and duties of a registered nurse.

b. Furthermore, Respondent engaged in unprofessional conduct by falsifying hospital records and by obtaining, possessing and self-administering controlled substances, when she diverted Vicodin in January of 2007, while employed at St. John's Medical Regional Center.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. RN 683607, heretofore issued to Respondent Erin Kelly Forest, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on June 10, 2011.

It is so ORDERED May 10, 2011

Jeannie K. Lee

FOR THE BOARD OF REGISTERED NURSING,
DEPARTMENT OF CONSUMER AFFAIRS

50843431.DOC
DOJ Matter ID:LA2010502564

Attachment: Exhibit A: Accusation

Exhibit A

Accusation

KAMALA D. HARRIS
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General
HELENE E. SWANSON
Deputy Attorney General
State Bar No. 130426
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 620-3005
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ERIN KELLY FOREST AKA ERIN KELLY ORTMANN** **P.O. Box 392** **Camarillo, CA 93011** **Registered Nurse License No. RN 683607** Respondent.	Case No. 2011-673 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 17, 2006, the Board of Registered Nursing (Board) issued Registered Nurse License No. RN 683607 to Erin Kelly Forest aka Erin Kelly Ortmann (Respondent). The Registered Nurse License expired on May 31, 2010, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 490 states:

"(a) In addition to any other action that a board is permitted to take against a licensee, a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

(b) Notwithstanding any other provision of law, a board may exercise any authority to discipline a licensee for conviction of a crime that is independent of the authority granted under subdivision (a) only if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the licensee's license was issued.

(c) A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action that a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code."

5. Section 2750 states:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof Code, § 2700 et seq.)]. As used in this article, "license" includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

. . . .

"(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof."

8. Section 2762 states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to

himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof."

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or intelligible entries in any hospital, patient, or other record pertaining to the substance described in subdivision (a) of this section."

9. Health and Safety Code section 11170 states: "No person shall prescribe, administer, or furnish a controlled substance for himself."

10. Health and Safety Code section 11173 states:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division."

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1444, states:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

. . . .

"(c) Theft, dishonesty, fraud, or deceit."

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COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

13. "Vicodin" a trade name for a combination drug containing hydrocodone bitartrate (opioid analgesic) and acetaminophen, is a Schedule III controlled substance as defined in Health and Safety Code Section 11056(e)(7), and is categorized as a dangerous drug according to Business and Professions Code section 4022.

14. "Fentanyl" is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055 (c)(8) used to alleviate pain, and is a dangerous drug pursuant to Business and Professions Code section 4022.

15. "Xanax" is a brand name for Alprazolam, a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057. It is a benzodiazepine used for the relief of anxiety, panic attacks and chronic sleeplessness.

16. "Ativan" is a brand name for Lorazepam, a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057. It is a benzodiazepine used for the relief of anxiety, panic attacks, and chronic sleeplessness.

17. "Dilaudid" is a brand name for Hydromorphone, a Schedule II controlled substance pursuant to Health and Safety Code Section 11055. It is a narcotic analgesic used for the relief of severe pain.

18. "Methadone" is a Schedule II controlled substance pursuant to Health and Safety Code section 1055. It is a narcotic used for the detoxification treatment of drug addiction (commonly used for addiction to heroin) and can be used for the relief of severe pain.

19. "Prestiq" (Desvenlafaxine) is a non-controlled substance that is used for the treatment of major depressive disorder in adults.

20. "Marijuana" (cannabis) is the most commonly used illicit drug, and consists of the dried leaves of the hemp plant, which are smoked or chewed for euphoric effect.

21. "Oxazepam" is a Scheduled IV controlled substance pursuant to Health and Safety Code section 11057. The brand name for Oxazepam is Serax. It is a narcotic therapeutic agent used to control emotional disorders associated with anxiety and depression.

PYXIS MEDICATION SYSTEM

22. The"Pyxis System" is an automated and computerized medication dispensing system, which operates similar to an ATM at a bank. The Pyxis medication dispensing machines are serviced by the facility's pharmacy. Medications are placed in the Pyxis machines, which are usually stationed throughout the hospital. These medications can only be accessed or withdrawn by an authorized staff person using their own unique personalized access code. Each medical professional at the hospital is assigned an account number and a "one time only" access code number. The access code number allows the individual to access the Pyxis System only one time. Upon making this initial access, the Pyxis System prompts the individual to enter his or her own unique access number or PIN code. The Pyxis System will not permit the use of a PIN code that has been used by any former employee, or is being used by any other current employee. After entering their own unique PIN code and each time the Pyxis System is accessed using that PIN code, the person making access is identified and a database record of the transaction is made, which is similar to the ATM withdrawal of funds from a bank account. The dispensing station makes a record of the medication and its dose, date and time it was withdrawn, the user identification, and patient for whom it was withdrawn.

FIRST CAUSE FOR DISCIPLINE

(Criminal Convictions)

23. Respondent is subject to disciplinary action under Sections 490 and 2761, subdivision (f), in conjunction with California Code of Regulations, Title 16, section 1444, in that Respondent was convicted of crimes which are substantially related to the qualifications, functions, and duties of a registered nurse, as follows:

a. On or about October 6, 2010, after a jury trial, Respondent was found guilty and convicted of one felony count of violating Penal Code section 459 [burglary] (considered to be a serious felony within the meaning of Penal Code section 1192.7, subdivision (c)) and one misdemeanor count of violating Penal Code section 368, subdivision (e) [elder abuse], in the criminal proceeding entitled *The People of the State of California v. Erin K. Forest* (Super. Ct. Ventura County, 2010, No. 2010018201- refiled from prior Case No. 2009041424). On or about October 14, 2010, Respondent was ordered to serve 180 days in custody, and to be screened for participation in a work furlough program. She was also placed on probation for a period of 36 months, and ordered to pay fines, fees and restitution. The circumstances surrounding the convictions are as follows:

b. Between approximately November 1, 2009 and November 11, 2009, Respondent unlawfully entered the homes of two elderly women, for whom she was working as a caretaker, at The Palms, 111 N. Wells Road, Ventura, California (senior assisted living residences), and stole their prescription medications (Vicodin and Fentanyl patches), the value of which collectively exceeded $800[1].

RESPONDENT'S DIVERSION OF CONTROLLED SUBSTANCES IN JANUARY 2007 AT SAINT JOHN'S MEDICAL REGIONAL CENTER

24. Between approximately August 28, 2006 and May of 2007, Respondent was employed as a staff nurse in the Telemetry Unit at Saint John's Medical Regional Center (SJMC) in Oxnard, California. During January 2007, while employed as a nurse at SJMC, Oxnard, California, Respondent withdrew numerous controlled substances from SJMC's Pyxis System, failed to document her alleged administration of these drugs to the related patients in their medical records, and then presumably diverted the controlled substances to herself.

25. When questioned by SJMC Director of Nursing Marilyn Butler about this, Respondent confessed that she had diverted unknown amounts of Vicodin from an unknown

[1] The names of the victims involved in the crimes at issue will be disclosed to Respondent upon request during the discovery phase of this case, as well as identifying information and documents concerning the patients referred to below in this Accusation.

number of patients at SJMC, for her own personal use. Respondent also admitted to SJMC Nurse Manager Robin Staples that she had developed an addiction to Vicodin as a result of a knee injury.

26. On or about May 8, 2007, Respondent was terminated from her nursing position at SJMC as a result of her admitted and substantiated controlled substance diversion, after failing to return from a non-paid administrative leave, the exclusive purpose of which was for Respondent to obtain assistance for her drug addiction from the Board. Respondent diverted controlled substances from nine patients more specifically as follows:

(1) Patient MRN: 1044327

27. On or about January 3, 2007 at 0830 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There was no physician's order for Vicodin for this patient until January 4, 2007. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record. On or about January 3, 2007, at 0936 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record, and there was a total discrepancy amount of 40 mg Vicodin.

28. On or about January 4, 2007 at 1112 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. On or about January 4, 2007 at 1857 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There were physician's orders for January 4, 2007 for Vicodin for these two time periods. On or about January 4, 2007 at 1924 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. There was no physician's order for Vicodin because this exceeded the time parameters of the physician's order. Respondent failed to account for the administration of Vicodin to this patient in any hospital record (i.e. did not reference the medication in the patient's medical records, did not chart any medication which may have been wasted, and did not prepare any nurses notes about the provision of the medication.)

29. On or about January 9, 2007 at 0823 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There were physician's orders for January 9, 2007 for Vicodin for this patient. On or about January 9, 2007 at 1016 hours, Respondent withdrew Vicodin 10 mg

from the Pyxis for this patient. On or about January 9, 2007 at 1225 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. On or about January 9, 2007 at 1618 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. On or about January 9, 2007 at 1827 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. Respondent failed to account for the administration of Vicodin in any hospital record.

30. On or about January 24, 2007 at 0905 (:09) hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There were physician's orders for Vicodin for this patient on this date and time. On or about January 24, 2007 at 0905 (:57) hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. There was no physician's order for Vicodin because this exceeded the time parameters of the physician's order. There was a discrepancy amount of Vicodin 15 mg. On or about January 24, 2007 at 1150 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. On or about January 24, 2007 at 1901 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. Respondent failed to account for the administration of any of the Vicodin in any hospital record.

31. On or about January 25, 2007 at 0839 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There were physician's orders for Vicodin for this patient on this date. On or about January 25, 2007 at 1321 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. On or about January 25, 2007 at 1513 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. On or about January 25, 2007 at 1514 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. There was a discrepancy of Vicodin 15 mg, and there was no physician's order for Vicodin 15 mg because the administration exceeded the doctor's time parameters. On or about January 25, 2007 at 1727 hours, Respondent withdrew Vicodin 10 mg from the Pyxis for this patient. On or about January 25, 2007 at 1923 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. Respondent failed to account for the administration of any Vicodin to this patient in any hospital record on this date. The total amount of discrepancies of Vicodin for this patient is 85 mg.

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(2) Patient MRN: 1035835

32. On or about January 3, 2007 at 1147 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There were no physician's orders for Vicodin for this patient on this date. On or about January 3, 2007 at 1534 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. On or about January 3, 2007 at 2011 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient. Respondent failed to account for the administration of Vicodin to this patient on this date in any hospital record. The total amount of discrepancies of Vicodin for this patient is 60 mg.

(3) Patient MRN: 1126009

33. On or about January 3, 2007 at 1730 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There were no physician's orders for Vicodin for this patient until January 4, 2007 at 1345, when 10 mg was ordered. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record. The total amount of discrepancies of Vicodin for this patient is 20 mg.

(4) Patient MRN: 1102385

34. On or about January 4, 2007 at 0816 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. The physician's order for Vicodin for this patient was only 10 mg. Respondent failed to account for the administration of 10 mg of Vicodin to this patient in any hospital record, and there was a discrepancy amount of 20 mg of Vicodin. On or about January 4, 2007 at 0817 hours, Respondent withdrew Xanax .25 mg from the Pyxis for this patient. There was a physician's order for Xanax for this patient, but for a later time. On or about January 4, 2007 at 0838 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient, which exceeded the time parameters of the physician's order for Vicodin for this patient. There was a discrepancy of Vicodin 15 mg. On or about January 4, 2007 at 1014 hours, Respondent withdrew Vicodin 10 mg from the Pyxis for this patient, which also exceeded the time parameters of the physician's orders. On or about January 4, 2007 at 1108 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, which exceeded the time parameters of the physician's orders. There was a discrepancy of Vicodin 20 mg. On or about January 4, 2007 at 1454 (:07) hours,

Respondent withdrew Xanax .50 mg from the Pyxis for this patient. Respondent failed to chart the medication and/or the amount of medication that was wasted. On or about January 4, 2007 at 1454 (:42) hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, but the physician's orders were only for 10 mg of Vicodin. Respondent failed to account for the administration of 10 mg of Vicodin to this patient in any hospital record.

35. On or about January 10, 2007 at 0827 hours, Respondent withdrew Vicodin 10 mg from the Pyxis for this patient. Respondent failed to chart the medication which was wasted, and failed to include the administration of the medication in the nurses notes. On or about January 10, 2007 at 1440 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, but the physician's order was for 10 mg of Vicodin only. Respondent referenced the 10 mg of Vicodin to this patient in the patient's chart, but did not include the amount of medication which was wasted and did not include this in the nurses notes. There was a discrepancy amount of 10 mg of Vicodin. On or about January 3, 2007 at 1444 hours, Respondent withdrew Vicodin 10 mg from the Pyxis for this patient, but this exceeded the time parameters of the physician's order for Vicodin for this patient. Respondent failed to account for the administration of 10 mg of Vicodin to this patient in any hospital record. Respondent failed to account for the 10 mg of Vicodin given to this patient in any hospital record, and there was a discrepancy amount of 10 mg of Vicodin. On or about January 10, 2007 at 1451 hours, Respondent withdrew Xanax .50 mg from the Pyxis for this patient. Respondent charted the medication, but did not include the amount of medication which was wasted, nor did she include the administration of this medication in the nurses notes. The total discrepancy of controlled substances for this patient is 85 mg of Vicodin.

(5) Patient MRN: 0198099

36. On or about January 9, 2007 at 0841 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There was no physician's order for Vicodin for this patient. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record. The total discrepancy of Vicodin for this patient is 20 mg.

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(6) Patient MRN: 1203080

37. On or about January 9, 2007 at 1125 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There was no physician's order for Vicodin for this patient on this date and time, and Respondent failed to account for the administration of this controlled substance in any hospital record. There was a discrepancy of 20 mg of Vicodin.

38. On or about January 12, 2007 at 0828 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient. There was no physician's order for Vicodin for this patient for this date. There was a discrepancy of 20 mg of Vicodin. On or about January 12, 2007 at 1124 hours, Respondent withdrew 20 mg and 15 mg of Vicodin from the Pyxis for this patient. There was a discrepancy of 35 mg of Vicodin. Respondent failed to account for the administration of Vicodin to this patient on this date in any hospital record. The total discrepancy of controlled substance diversion for this patient is 75 mg of Vicodin.

(7) Patient MRN: 1039758

39. On or about January 9, 2007 at 1345 hours, Respondent withdrew Ativan 2 mg from the Pyxis for this patient, for which there was a physician's order. Respondent charted the medication and made an entry in the nurses notes, but failed to chart the medication which was wasted. On or about January 9, 2007 at 1424 hours, Respondent withdrew Dilaudid 50 mg from the Pyxis for this patient. Respondent failed to chart the medication which was wasted. On or about January 9, 2007 at 1508 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record, and there was a discrepancy of 20 mg of Vicodin. On or about January 9, 2007 at 1832 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 15 mg of Vicodin to this patient in any hospital record, and there was a discrepancy of 15 mg of Vicodin. On or about January 9, 2007 at 1853 hours, Respondent withdrew Ativan 2 mg from the Pyxis for this patient. Respondent failed to chart the medication which was wasted.

40. On or about January 10, 2007 at 0812 hours, Respondent withdrew Ativan

2 mg from the Pyxis for this patient, for which there was a physician's order. Respondent failed to chart the amount of medication which was wasted. On or about January 10, 2007 at 0914 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, for which there was no physician's order. There was a discrepancy of 20 mg of Vicodin. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record. On or about January 10, 2007 at 1217 hours, Respondent withdrew Ativan 2 mg from the Pyxis for this patient. Respondent failed to chart the medication which was wasted. On or about January 10, 2007 at 1218 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record, and there was a discrepancy of 20 mg of Vicodin. On or about January 10, 2007 at 1725 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record, and there was a discrepancy of 20 mg of Vicodin. On or about January 10, 2007 at 1736 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 15 mg of Vicodin to this patient in any hospital record, and there was a discrepancy of 15 mg of Vicodin. On or about January 10, 2007 at 1816 hours, Respondent withdrew Ativan 2 mg from the Pyxis for this patient. Respondent failed to chart the medication which was wasted. On or about January 10, 2007 at 1957 hours, Respondent withdrew Vicodin 15 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 15 mg of Vicodin to this patient in any hospital record. The total discrepancy of controlled substance diversion amount for this patient is 125 mg of Vicodin.

(8) Patient MRN: 1034414

41. On or about January 10, 2007 at 1101 hours, Respondent withdrew Xanax .50 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of .50 mg of Xanax to this patient in any hospital record, and there was a discrepancy of .50 mg of Xanax for this patient.

(9) Patient MRN: 1086401

42. On or about January 10, 2007 at 1254 hours, Respondent withdrew Vicodin 20 mg from the Pyxis for this patient, for which there was no physician's order. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record. On or about January 10, 2007 at 1815 hours, Respondent again withdrew Vicodin 20 mg from the Pyxis for this patient, without a physician's order for Vicodin for this patient. Respondent failed to account for the administration of 20 mg of Vicodin to this patient in any hospital record. The total discrepancy is 40 mg of Vicodin for this patient.

43. The total combined discrepancies for Respondent's diversion of controlled substances from the aforementioned nine patients in January of 2007 amounted to 510 mg of Vicodin and .50 mg of Xanax. When interviewed by the Board's investigator, she admitted that she had diverted Vicodin from SJMC, and claimed that it was due to her addiction to Vicodin which was caused by knee pain. She estimated she had diverted around 80-100 mg of Vicodin from 10 of SJMC's patients, but denied diverting .50 mg of Xanax from SJMC. Furthermore, she told the Board's investigator that she self-administered the Vicodin only after she had completed her SJMC employment shifts, and denied ever having been under the influence of a controlled substance while on duty at SJMC. Respondent claimed that, after she diverted controlled substances from SJMC, she was successfully treated for her drug addiction at Vista Del Mar Hospital's in-patient drug addiction treatment facility in Ventura, California, and claimed that her Vicodin addiction was now under control. However, when questioned further about her sobriety, she stated to the investigator that her friends had offered her Vicodin at a few parties, which she took.

44. In addition, Respondent told the Board's investigator that she smoked Marijuana at a social gathering that week, and that a physician had prescribed .5 mg of Vicodin twice a day and the anti-depressant Prestiq (a non-controlled substance) to her. When told she would be drug screened, Respondent also disclosed to the investigator that a physician had prescribed Methadone to her for various anxiety disorders, but not as a substitute for heroin. Respondent took a drug screening test, which showed she tested positive for marijuana, methadone and Oxazepam in her system.

SECOND CAUSE FOR DISCIPLINE

(Obtain, Possess and Self-Administer Controlled Substances)

45. Respondent is subject to disciplinary action under Section 2761, subdivision (a) and (d), on the grounds of unprofessional conduct as defined in Section 2762, subdivision (c), in that during January 2007, while employed as a licensed registered nurse by SJMC, California, Respondent admitted she diverted Vicodin and self-administered it to herself, as set forth above in Paragraphs 24 through 44, as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(False, Incorrect, Inconsistent or Unintelligible Records)

46. Respondent is subject to disciplinary action under Section 2761, subdivisions (a) and (d) of the Code on the grounds of unprofessional conduct as defined by Section 2762, subdivision (e) of the Code, and pursuant to Health and Safety Code Section 11173, subdivision (b), in that Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances. Complainant refers to, and by this reference incorporates, the allegations set forth above in Paragraphs 24 through 44, as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

47. Respondent is subject to disciplinary action under Section 2761, subdivision (a) of the Code, in that during January 2007, Respondent committed acts of unprofessional conduct by failing to account for administration or wastage of medications signed out in hospital records, by signing out more medication than was ordered, and by signing out medications without a physician's order. Complainant refers to, and by this reference incorporates, the allegations set forth above in Paragraphs 24 through 44, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Violation of the Nursing Practice Act)

48. Respondent is subject to disciplinary action under Section 2761, subdivision (d) of the Code, on the grounds of unprofessional conduct, in that Respondent violated or attempted to

violate, directly or indirectly the provisions of the Nursing Practice Act. Complainant refers to, and by this reference incorporates, the allegations set forth above in Paragraphs 24 through 44, as though fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 683607, issued to Erin Kelly Forest aka Erin Kelly Ortmann;

2. Ordering Erin Kelly Forest aka Erin Kelly Ortmann to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/1/11

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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